

Division of Health Care Facilities

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|--|---|---|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>TN6305</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____                             | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C</b><br><b>10/31/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PALMYRA HEALTH AND REHABILITATION</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2727 PALMYRA RD</b><br><b>PALMYRA, TN 37142</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)        | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE   |
| {N 000}  | Initial Comments<br><br>During the follow up survey conducted on<br>10/31/2019 all previously cited deficiencies were<br>corrected. | {N 000}   |  |  |

Division of Health Care Facilities  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE